RSU No 5 Durham - Freeport - Pownal
STUDENT HEALTH HISTORY
To be completed annually by Parent/Guardian

Student Name: _____ Date of Birth: _____ Grade: _____

Please check any EMERGENCY Health Conditions that your child has:
Asthma _____ Diabetes _____ Seizures _____ Heart Condition _____ Other _____

Specify if your child has a LIFE-THREATENING ALLERGY to:
Foods _____Medications _____Stings _____Other _____
An Individual Action/Management Plan must be signed by the PCP each school year for any of these conditions.
These potentially life-threatening / emergency conditions will be included on a Medical Alert List

MEDICATIONS taken at home (name of medication, dose & frequency): _____
_____
_____

Describe any other Health Conditions below: symptoms, treatment, frequency, and child's age/date that it occurred.
These conditions will be included in your child's school health record.

Allergies (non-life-threatening) or Sensitivities: _____
Behavioral/Social-Emotional/Mental Health Problems: _____ Diagnosed ADD/ADHD: _____
Bones/Joints/Muscle Coordination: _____ Scoliosis: _____ Treatment: _____
Bowel/Digestive/Stomach Problems: _____
Bronchitis/Chronic Cough/Pneumonia/Wheezing: _____
Ear/Hearing Problems: _____ Tubes in Ears: _____ Hearing Aid(s): R_____ L_____
Eye/Vision Problems: _____ Glasses: _____ Contacts: _____
Head Aches/Migraines/Dizzy Spells/Fainting: _____ History of Concussion: _____
Menstrual Issues: _____
Nutrition/Special Dietary Needs: _____
Skin Problems: _____
Speech Problems: _____
Teeth: Condition? _____ Last Dental Exam: _____
Other Health Concerns: _____

Has your child had: Chicken Pox Disease?_____ Pertussis (Whooping Cough)? _____
Does your child use: Crutches _____ Wheel Chair _____ Braces (Arms/Legs) R _____ L _____ Other: _____
Accidents/Hospitalizations/Surgery: _____

Does your child have **Health Insurance**? Yes _____ No _____ Insured under **Maine Care**? Yes _____ No _____
If you or your child needs assistance with Health Insurance: CALL 1-800-965-7476 or www.mainecahc.org
Do you need help to find **Dental Care** for you child? Yes_____ No_____

Physician: _____ Phone/Fax: _____
Dentist: _____ Phone/Fax: _____
Eye care: _____ Phone/Fax: _____
Other Specialists, Counselors, etc. _____

- I give permission for Release of Information on this form for confidential use to meet my child's education and health needs in school. Medical Alert information will be provided to appropriate school personnel responsible for my child during the school day.
- I authorize exchange of information with my child's physician for required school Physical Examination and Immunization Records. I understand that when there is this exchange of information, I will be notified.
- I recognize that school personnel will take the appropriate steps in a medical situation, including calling Rescue 911.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Print Name: _____
Contact information: Home: _____ Work: _____ Cell: _____